MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Vision Care

April 2007 • Bulletin 350

Contents

Medi-Cal Training Seminars

New Claim Form Billing Instructions 1

DME Medicare/Medi-Cal Crossover Contractor Update 1

CCS Service Code Groupings Update 2

NPI Dual-Use Period Instructions

Preview CMS-1500 Claim Instructions

New Claim Form Billing Instructions

To ensure that providers have the most current information available regarding the new *CMS-1500* claim form, the California Department of Health Services is releasing a preview of the provider manual claim form completion section *New CMS-1500 Sample and Instructions* and *NPI Dual-Use Period* instructions with this *Medi-Cal Update*.

The preview, *New CMS-1500 Sample and Instructions*, is found at the end of the Part 2 bulletin. Retain these instructions until the May 2007 *Special Update* arrives.

Providers are urged to read the claim form completion instructions immediately to understand how to bill using the new claim forms. Providers may begin using the new claim forms on April 23, 2007. Use of the new claim forms becomes mandatory on June 25, 2007.

Medi-Cal has instituted a provider number dual-use period from May 23, 2007 through November 25, 2007. During that time, providers must use their Medi-Cal provider number and, if available, also enter their NPI.

The guidelines for submitting proprietary claim forms will not change during the claim form transition period. For a complete list of forms, see the article, "Provider Number Dual-Use Period Begins May 23, 2007," in this bulletin.

DME Medicare/Medi-Cal Crossover Contractor Update

Effective October 1, 2006, Noridian Administrative Services (NAS) replaced CIGNA as a Medicare/Medi-Cal administrative contractor. Noridian's responsibility is to transmit Durable Medical Equipment (DME), prosthetic, orthotic and medical supply Medicare/Medi-Cal crossover claims to EDS. Noridian is referred to as a Durable Medical Equipment Medicare Administrative Contractor (DMAC). CIGNA was referred to as a DME Regional Carrier (DMERC).

Manual Updates

As a result of this change, references to CIGNA are being removed from the Medi-Cal provider manuals and replaced with "Noridian." In addition, references to DMERC are being changed to DMAC.

This information is reflected on manual replacement pages medicare 4 and 9 (Part 1) and eye app 10 (Part 2)

CCS Service Code Groupings Update

Retroactive for dates of service on or after November 1, 2006, a number of codes are added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 07 and 09.

Effective retroactively for dates of service on or after July 1, 2004, new SCG 12 is added for Podiatry.

HCPCS code J0885 was inadvertently added to SCG 09. It is only included in SCGs 01, 02, 03 and 07.

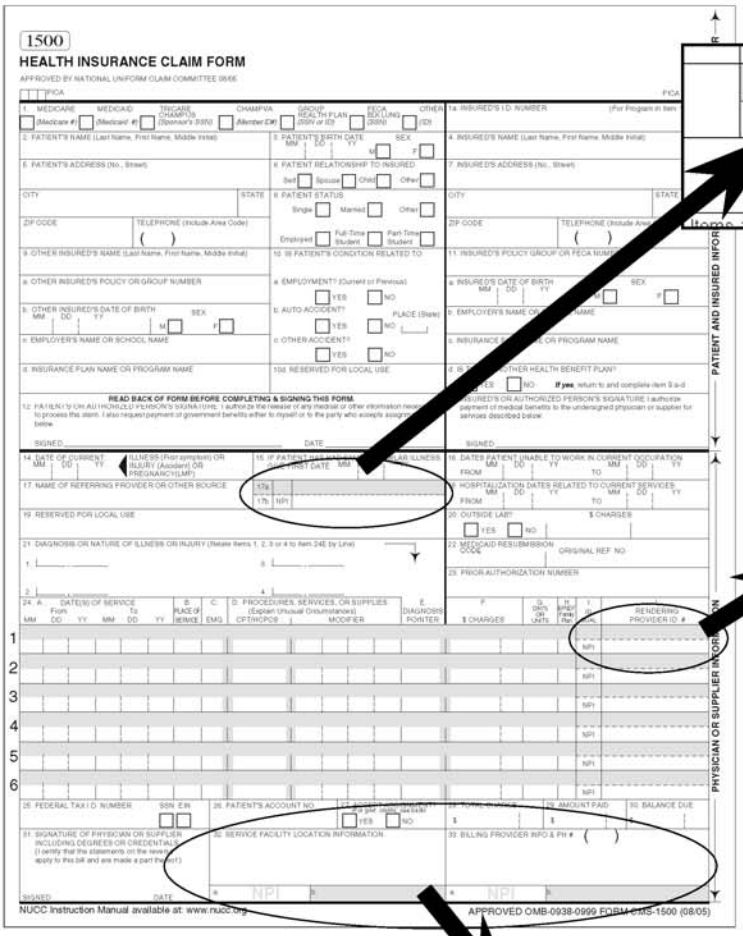
Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

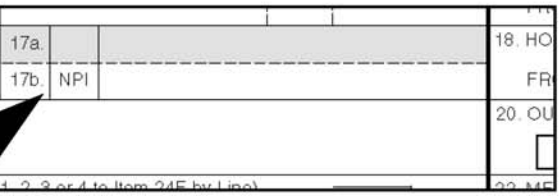
The updated information is reflected on manual replacement pages cal child ser 1, 5, 11 thru 13, 22 and 24 thru 27 (Part 2).

NPI Dual-Use Period

May 23, 2007 through November 25, 2007

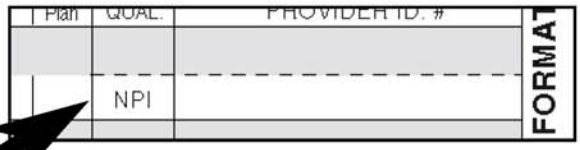
Follow these simple rules, and your *CMS-1500* claims will pass the provider identifier test! You **must** use a Medi-Cal provider number. You **may** also include an NPI in the following boxes of the claim. (Claims received with *only* an NPI will **not** be processed.)





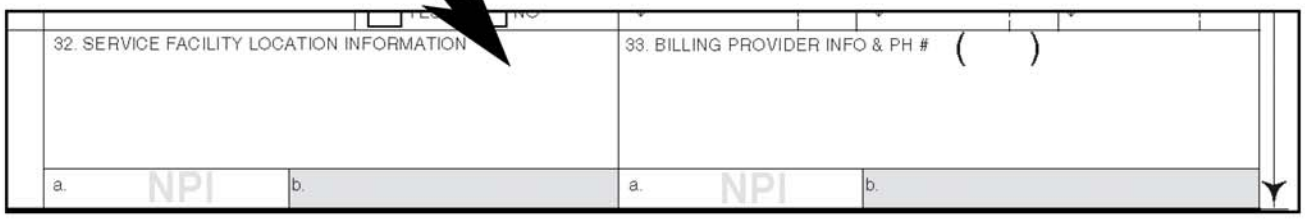
BOX 17

Enter the referring provider's Medi-Cal number in **Box 17A** and NPI in **Box 17B**.



BOX 24J

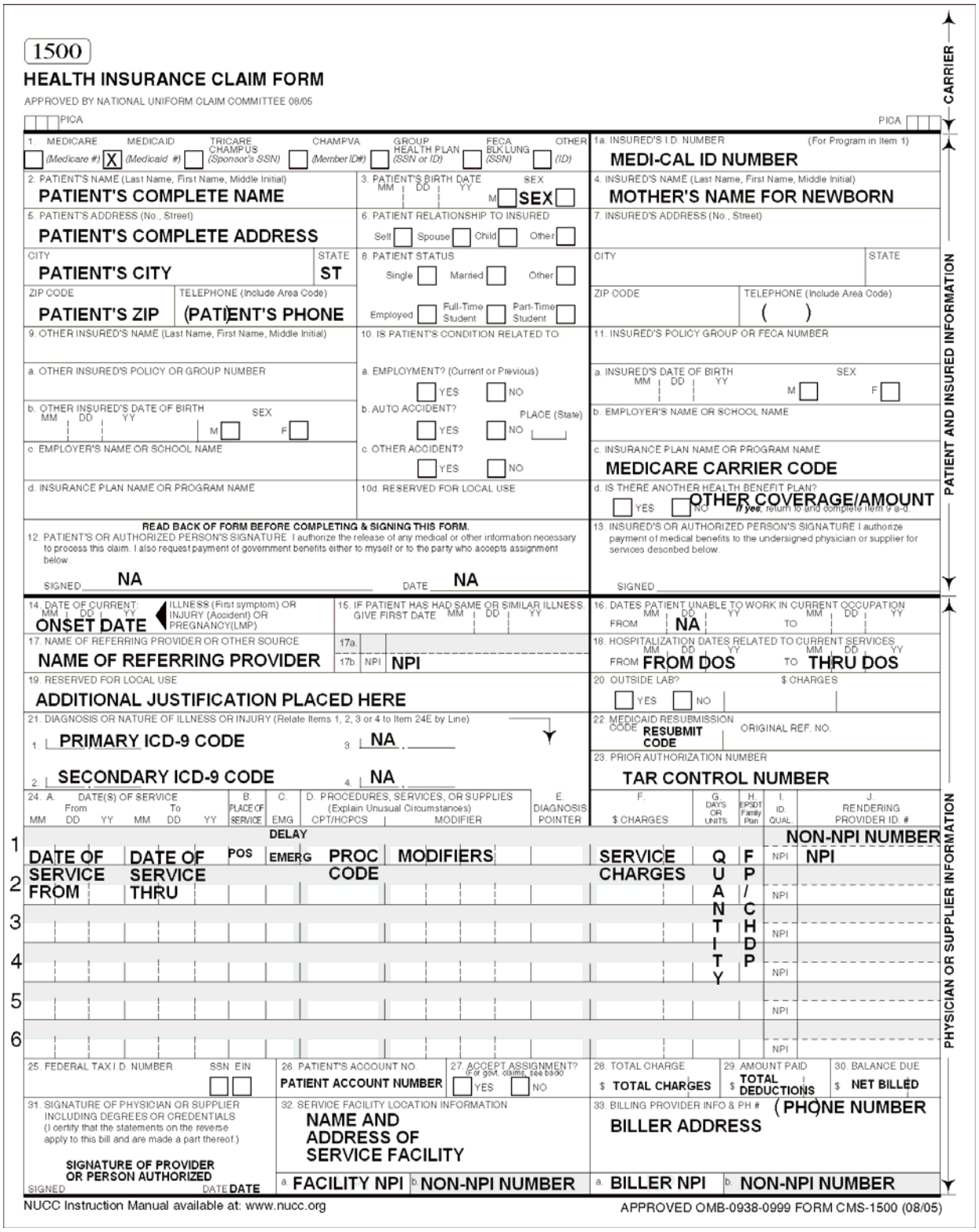
When necessary, enter the rendering provider's Medi-Cal number in the shaded area of **Box 24J** and NPI in the unshaded area.



BOX 32: Enter the service facility's NPI in **Box 32A** and Medi-Cal number in **Box 32B**.

BOX 33: Enter the billing provider's NPI in **Box 33A** and Medi-Cal number in **Box 33B**.

New CMS-1500 Sample and Instructions for Vision Care
Medi-Cal Required Fields



Explanation of Form Items

The following item numbers and descriptions correspond to the sample *CMS-1500* on the previous page and are unique to Medi-Cal. All items must be completed unless otherwise noted in these instructions.

Note: Items described as "Not required by Medi-Cal" (NA) may be completed for other payers but are not recognized by the Medi-Cal claims processing system.

UNDESIGNATED WHITE SPACE. Do not type in the top one inch of the *CMS-1500* claim form, because this area is reserved for EDS use.

Item	Description

1. **MEDICARE/MEDICAID/OTHER ID.** If the claim is a Medi-Cal claim, enter an "X" in the Medicaid box. If submitting a Medicare/Medi-Cal claim, use a copy of the original *CMS-1500* billed to Medicare and enter an "X" in both the *Medicaid* and *Medicare* boxes.

   Note: For more information about crossover claims, refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.

1A. **INSURED'S ID NUMBER.** Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

2. **PATIENT'S NAME.** Enter the recipient's last name, first name, middle initial (if known).

3. **PATIENT'S BIRTH DATE/SEX.** Enter the recipient's date of birth in six-digit MMDDYY (Month, Day, Year) format. Enter an "X" in the "M" or "F" box (as indicated on the BIC).

4. **INSURED'S NAME.** Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant.

   When submitting a claim for a newborn infant using the mother's ID number and the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl) in Box 2 (Patient's Name) of the *CMS-1500* claim form.

   Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.

5. **PATIENT'S ADDRESS/TELEPHONE.** Enter recipient's complete address and telephone number.

6. **PATIENT RELATIONSHIP TO INSURED.** Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the *Child* box.

7. **INSURED'S ADDRESS.** Not required by Medi-Cal.

8. **PATIENT STATUS.** Not required by Medi-Cal.

Item	Description
9.	**OTHER INSURED'S NAME.** Not required by Medi-Cal.
9A.	**OTHER INSURED'S POLICY OR GROUP NUMBER.** Not required by Medi-Cal.
9B.	**OTHER INSURED'S DATE OF BIRTH.** Not required by Medi-Cal.
9C.	**EMPLOYER'S NAME OR SCHOOL NAME.** Not required by Medi-Cal.
9D.	**INSURANCE PLAN NAME OR PROGRAM NAME.** Not required by Medi-Cal.
10A.	**IS PATIENT'S CONDITION RELATED TO.EMPLOYMENT.** Complete this field if services were related to an accident or injury. Enter an "X" in the *Yes* box if accident/injury is employment related. Enter an "X" in the *No* box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in Box 14.
10B.	**IS PATIENT'S CONDITION RELATED TO AUTO ACCIDENT/PLACE.** Not required by Medi-Cal.
10C.	**IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT.** Not required by Medi-Cal.
10D.	**RESERVED FOR LOCAL USE (Share of Cost).** Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply.
11.	**INSURED'S POLICY GROUP OR FECA NUMBER.** Not required by Medi-Cal.
11A.	**INSURED'S DATE OF BIRTH/SEX.** Not required by Medi-Cal.
11B.	**EMPLOYER'S NAME OR SCHOOL NAME.** Not required by Medi-Cal.
11C.	**INSURANCE PLAN NAME OR PROGRAM NAME.** For Medicare/Medi-Cal crossover claims. Enter your Medicare Carrier Code.
11D.	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Enter an "X" in the *Yes* box if recipient has Other Health Coverage (OHC). If the OHC has paid, enter the amount in the upper right side of this field. **Note:** Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is <u>not</u> considered Other Health Coverage.
12.	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.** Not required by Medi-Cal.
13.	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.** Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.
14.	**DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP).** Enter the date of onset of the recipient's illness, the date of accident/injury.

Item Description

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE.** Not required by Medi-Cal.

16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.** Not required by Medi-Cal.

17**.** **NAME OF REFERRING PROVIDER OR OTHER SOURCE.** Not required by Medi-Cal.

17A. **UNLABELED.** Not required by Medi-Cal.

17B. **NPI.** Not required by Medi-Cal.

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.** Enter the dates of hospital admission and discharge, if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.

19. **RESERVED FOR LOCAL USE.** Use this area for procedures that require additional information, justification or an Emergency Certification Statement.

Refer to the policy sections of this manual for CPT-4/HCPCS codes that require additional justification. If the information requested requires additional space than what is provided in Box 19, include a separate attachment on an 8½ x 11-inch sheet of paper with the claim.

If electronically filing a claim with attachments, enter the Attachment Control Number (ACN) from the Attachment Control Form (ACF).

20. **OUTSIDE LAB?** If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X". "Outside" laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including fourth and fifth digits, if present.

Note: For vision services, enter up to two diagnosis codes in Fields 21.1 and 21.2. Do not enter more than two diagnosis codes. If billing for multiple procedure codes that require different diagnosis codes than what can be entered in Fields 21.1 and 21.2, use a separate claim.

22. **MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.** Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.

Code	Explanation
0	Younger than 65, does not have Medicare coverage
1 *	Benefits exhausted
2 *	Utilization committee denial or physician non-certification
3 *	No prior hospital stay
4 *	Facility denial

Item Description

22. **MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO. (continued)**

Code	Explanation
5 *	Non-eligible provider
6 *	Non-eligible recipient
7 *	Medicare benefits denied or cut short by Medicare intermediary
8	Non-covered services
9 *	PSRO denial
L *	Medi/Medi Charpentier: Benefit Limitation
R *	Medi/Medi Charpentier: Rate Limitation
T *	Medi/Medi Charpentier: Both Rates and Benefit Limitation

* Documentation is required.

23. **PRIOR AUTHORIZATION NUMBER.** For Vision care services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number and Pricing Indicator.

24.1 **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions for Vision Care* section in this manual for more information.

Note: Do not enter data in the shaded area, except for Box 24C.

24A. **DATE(S) OF SERVICE.** Enter the date the service was rendered in the "From" and "To" boxes in the six-digit, MMDDYY (Month, Day, Year) format.

24B. **PLACE OF SERVICE.** Enter code indicating where service was rendered.

Code	Place of Service
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
65	End Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service (Describe in *Reserved for Local Use* field [Box 19])

Item	Description

24C. **EMG.** Emergency or delay reason codes.

Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. (Refer to the *CMS-1500 Submission and Timeliness Instructions* section in this manual.)

Emergency Code: Only one emergency indicator is allowed per claim, and must be placed in the bottom unshaded portion of Box 24C. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required prior authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist, or pharmacist's statement, describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient.

24D. **PROCEDURES, SERVICES OR SUPPLIES.** Enter the applicable procedure code (HCPCS or CPT-4) and modifier.

24E. **DIAGNOSIS POINTER.** As required by Medi-Cal.

24F. **CHARGES.** In full dollar amount, enter the usual and customary fee for service(s).

Note: When billing "outside" laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.

24G. **DAYS OR UNITS.** Enter the number of medical "visits" or procedures, surgical "lesions," hours of "detention time," units of anesthesia time, items or units of service, etc.

Note: Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter "4").

24H. **EPSDT FAMILY PLAN.** Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

24I. **ID QUALIFIER FOR RENDERING PROVIDER.** Not required by Medi-Cal.

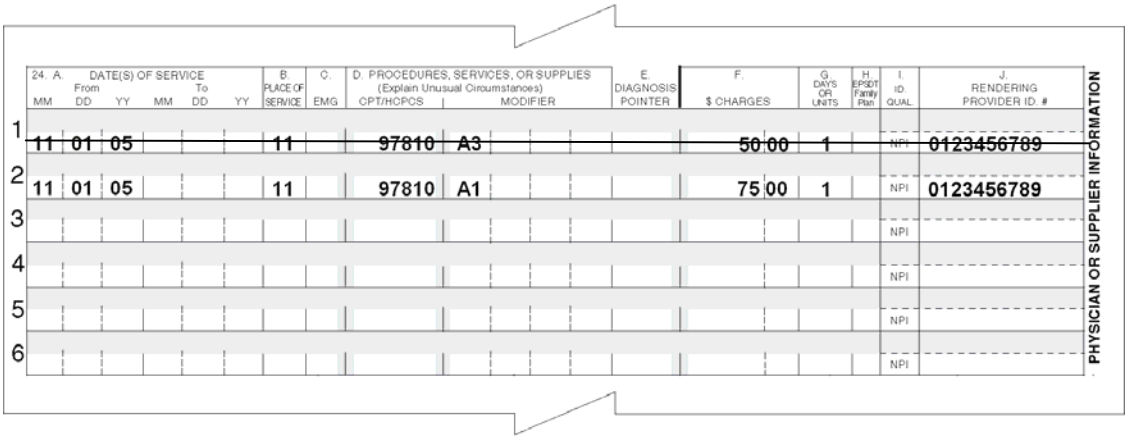
24J. **RENDERING PROVIDER ID NUMBER.** Enter the NPI for rendering provider, if the provider is billing under a group NPI.

The rendering provider instructions apply to services rendered by the following providers:

- Optometrists
- Ophthalmologists

Item	Description
Deleting Information: Items 24A thru 24J	If an error has been made to specific billing information entered on Items 24A thru 24J, draw a line through the entire detail line using a blue or black ballpoint pen. Enter the correct billing information on another line.

Note: Do not "black-out" entire claim line. Deleted information may be used to determine previous payment.



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	01	05				11		97810	A3		50 00	1		NPI	0123456789
2	11	01	05				11		97810	A1		75 00	1		NPI	0123456789
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Sample of Deleted Information.

24.2 – 24.6 **ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.

25. **FEDERAL TAX I.D. NUMBER.** Not required by Medi-Cal.

26. **PATIENT'S ACCOUNT NO.** This is an optional field that will help providers to easily identify a recipient on a *Resubmission Turnaround Document* (RTD) and *Remittance Advice Details* (RAD). Enter the patient's medical record number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RTD and RAD. Refer to the *Resubmission Turnaround Document* (RTD) completion and *Remittance Advice Details* (RAD) examples sections in this manual.

27. **ACCEPT ASSIGNMENT.** Not required by Medi-Cal.

28. **TOTAL CHARGE.** Enter the full dollar amount, for all services, without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000."

29. **AMOUNT PAID.** Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D).

Item	Description
30.	**BALANCE DUE.** Enter the difference between *Total Charges* and *Amount Paid*.
31.	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.** The claim must be signed and dated by the provider or a representative assigned by the provider in black ballpoint ink. Providers that fill another provider's prescription must keep a copy of the prescription in the recipient's medical record, which must be made available for state review if requested. **Note:** Signatures must be written, not printed, and should not extend outside the box. Stamps, initials or facsimiles are not accepted.
32.	**SERVICE FACILITY LOCATION INFORMATION.** Not required for vision services.
33.	**BILLING PROVIDER INFO AND PHONE NUMBER.** Enter the provider name, address, nine-digit ZIP code and telephone number.
33A.	Enter the billing provider's NPI.
33B.	Used for atypical provider's only. Enter the Medi-Cal provider number for the billing provider. **Note:** Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill numbers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.

Check Digits

The California Department of Health Services (CDHS) assigns a check digit to each provider to verify accurate input of the Medi-Cal provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 33B. Providers who do not know their check digit should contact the EDS Telephone Service Center (TSC) at 1-800-541-5555.

Instructions for Manual Replacement Pages — Part 2

April 2007

Vision Care Bulletin 350

Remove and replace:	cal child ser 1/2, 5/6, 11 thru 14
Remove:	cal child ser 21 thru 24
Insert:	cal child ser 21 thru 27
Remove and replace:	eye app 9/10